

APPLICATION FOR MEDI-CAL

To complete this form, use the instructions. Print clearly. Use black or blue ink only.

SECTION 1 Tell us about the person who wants Medi-Cal for themselves, their family or children in their care.

1 LAST NAME		FIRST NAME		MIDDLE INITIAL	
2 HOME ADDRESS (NUMBER AND STREET). DO NOT LIST A P.O. BOX UNLESS HOMELESS			3 APARTMENT NUMBER	4 HOME PHONE # ()	
5 CITY	6 COUNTY/STATE		7 ZIP CODE	8 WORK PHONE # ()	
9 MAILING ADDRESS (IF DIFFERENT FROM ABOVE) OR P.O. BOX			10 APARTMENT NUMBER	11 MESSAGE PHONE # ()	
12 CITY			13 ZIP CODE		
14A WHAT LANGUAGE/DIALECT DO YOU SPEAK BEST?			14B WHAT LANGUAGE DO YOU READ BEST?		

SECTION 2 Tell us about the person listed in Section 1, his or her family and the children they care for, even if they don't want coverage.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
15 Name:					
Last					
First					
Middle					
16 Relationship to person in Section 1.					
17 If address where living is not the same as listed in Section 1, put address where living:					
18 Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
19 Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
20 Name of spouse(s) of married minors in the home.					
21 Date of Birth:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
22 Pregnant:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Due Date:	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR	/ / MO DAY YR
23 Has a physical, mental or emotional disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability expected to last:	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More	<input type="checkbox"/> 30 Days or More <input type="checkbox"/> 12 Months or More

SECTION 2 Continued		Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
24	Has any one ever received cash aid, SSI, Food Stamps or Medi-Cal? If "Yes," under what name?	Yes No	Yes No	Yes No	Yes <input type="checkbox"/> No	Yes No
25	Medi-Cal benefits BIC card number, if you have it:					
26	Wants Medical benefits?	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
27	Do you own or are you buying a home outside California?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3 Answer for **all** children in Section 2.

28	Mother's Name:	Mother's Name:		Mother's Name:		Mother's Name:	
Is Mother:	Employed Disabled Deceased	Employed Unemployed Absent	Is Mother:	Employed Disabled Deceased	Employed Unemployed Absent	Is Mother:	Employed Disabled Unemployed
29	Father's Name:	Father's Name:		Father's Name:		Father's Name:	
Is Father:	Employed Disabled Deceased	Employed Unemployed Absent	Is Father:	Employed Disabled Deceased	Employed Unemployed Absent	Is Father:	Employed Disabled Unemployed Deceased

SECTION 4 List **all** income/money received by persons listed in Section 2.

30	NAME OF PERSON RECEIVING INCOME/MONEY	31	SOURCE OF INCOME/ MONEY RECEIVED (Employment, social security)	32	HOW MUCH INCOME/MONEY IS RECEIVED	33	HOW OFTEN INCOME/ MONEY RECEIVED (Monthly, bimonthly, weekly, biweekly, daily)

SECTION 5 Give information about the listed expenses/cost paid by **all** persons listed in Section 2.

TYPE OF PAYMENT YOUR FAMILY MAKES	34	NAME OF PERSON WHO PAYS	35	MONTHLY AMOUNT PAID	36	CHILD CARE OR DEPENDENT CARE (List child's or dependent's name)	37	AGE	38	NAME OF PERSON WHO PAYS	39	MONTHLY AMOUNT PAID
Child Support					1.							
Alimony					2.							
Other Health Insurance Premium					3.							
Medicare Premium					4.							

TEAR HERE

SECTION 6

*Skip this Section if you are **only** applying for children under 19 and/or pregnant women (pregnancy related services only).*

Otherwise answer for **all** persons listed in Section 2.

- 40** Does anyone have cash or uncashed checks?
If "Yes," list amount here _____ (See instructions) ☐ Yes ☐ No
- 41** Does anyone have a checking, savings account, or life insurance? (See instructions) ☐ Yes ☐ No
- 42** Is there one car or more in the household? (See instructions) ☐ Yes ☐ No
- 43** Does anyone have a court ordered settlement or judgement? (See instructions) ☐ Yes ☐ No
- 44** Does anyone have Long-Term Care insurance? (See instructions) ☐ Yes ☐ No
- 45** Does anyone own any items such as stocks, bonds, retirement funds, trusts, real estate, motor vehicles for a business, business accounts, promissory notes, mortgages, deeds of trust, recreational vehicles, burial trusts or funds, annuities, jewelry (not heirloom or wedding), oil or mineral rights? (See instructions) ☐ Yes ☐ No
- 46** Has anyone listed on this form, transferred, sold, traded or given away any items such as those listed above in the last 30 months? (See instructions) ☐ Yes ☐ No
- 47** Have any items listed in this section been spent or used as security for medical costs? (See instructions) ☐ Yes ☐ No

SECTION 7

Answer **only** for persons who want Medi-Cal.

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
48 Social Security #:					
You may be able to receive Medi-Cal even if you do not have a Social Security Number.					
49 Place of Birth: <i>State or Country.</i>					
50 U.S. Citizen or National? If "No," write in date of entry into U.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR	<input type="checkbox"/> Yes <input type="checkbox"/> No / / MO DAY YR
51 Living in a Long-Term Care or Board and Care Facility?	<input type="checkbox"/> Yes No	Yes No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No
If "Yes," name of facility:					
Do you intend to return home?	<input type="checkbox"/> Yes No	Yes No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes No	Yes No
Do you intend to return home within six months?	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes No
52 Has health/dental or vision coverage?	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No	Yes No
53 Had medical expenses within the 3 months before the month you applied and want Medi-Cal for those expenses.	Yes No	Yes No	Yes No	Yes No	Yes No
54 Lawsuit pending due to accident or injury?	Yes No	Yes <input type="checkbox"/> No	Yes No	<input type="checkbox"/> Yes No	<input type="checkbox"/> Yes No

TEAR HERE

SECTION 7 Continued

	Adult 1/Self	Adult 2	Child 1	Child 2	Child 3
55 Current or past U.S. Military Service for adults, spouse or child's parents?	Yes No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Yes <input type="checkbox"/> No Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Yes No <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes No Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	<input type="checkbox"/> Yes No Self Spouse Parent
56 Ethnicity (race): (optional)					
57 In school full time?	Yes <input type="checkbox"/> No	Yes <input type="checkbox"/> No	Yes No	Yes No	Yes No
58 Living away from home?	Yes No	Yes <input type="checkbox"/> No	Yes No	Yes No	Yes No

SECTION 8 Information Release (Optional).

59 If family member cannot get no-cost Medi-Cal but may be able to get low-cost health care coverage, can the local welfare office send this form to the Healthy Families Program? ☐ Yes ☐ No

60 I got help from (give name of person) _____ when I filled out this application. I agree that the local welfare office may give them information about the status of this application. **Applicant please initial** _____

SECTION 9 Signature and Certification.

61 I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application, and the documents given are correct and true to the best of my knowledge and belief.
I declare that I have read and understand the application instructions, the declarations, and all information printed on this application.

Signature Date

Witness Signature (If person signed with a mark) Date

Signature of person helping Applicant fill out the form Telephone Number Relationship to Applicant Date

Signature of person acting for Applicant/Beneficiary Telephone Number Relationship to Applicant Date

For information about any of the following programs, check the box(es) below and information will be sent to you. See the Medi-Cal brochure, "Health Care for Families with Children" or visit our website, www.dhs.ca.gov

Personal Care Service Program (PCSP). A program for in-home care.

Access for Infants, and Mothers (AIM). A program to help pregnant women with moderate income obtain health care.

Woman, Infants and Children Nutrition Program (WIC). A nutrition program for pregnant and postpartum women and children under 5.

Family Planning

Child Health and Disability Program (CHDP). Preventive healthcare for children and youth.

Do you want your children or youth referred to the CHDP program? Yes No